Wyoming Department of Health – Communicable Disease HIV, Hepatitis and STD Risk Assessment

FACILITY INFORMATION

Today's Date: _____
Facility Name: _____
Facility Address: _____
Facility Phone number: _____
Client ID: _____

Client: Please complete pages one and two of this document. The following information will be helpful for your provider to determine proper screening and/or vaccination needs for this visit.

DEMOGRAPHICS

Patient Name: _____ DOB: _____ Age: _____
Address: _____ City: _____ Zip: _____
Phone: _____ Email: _____
Preferred Method of Contact by Clinic: ☐ Phone ☐ Email ☐ Mail ☐ Other: _____
Contact Restrictions: _____

How did you hear about us?
☐ Knowyo.org ☐ Poster ☐ Word of Mouth ☐ Radio ☐ Billboard ☐ Newspaper ☐ WDH staff ☐ Other _____

Race (check all that apply): ☐ White ☐ Black/African American ☐ Native American/Alaskan Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Other ☐ Don't know ☐ Decline to answer

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Don't know ☐ Decline to answer

Current Gender: ☐ Male ☐ Female ☐ Transgender (male to female) ☐ Transgender (female to male)
Sexual Orientation: ☐ Heterosexual ☐ Gay Male ☐ Lesbian ☐ Bisexual ☐ Do not wish to answer

SEXUAL HEALTH AND HISTORY

How knowledgeable are you about STDs, HIV and Viral Hepatitis? ☐ Very ☐ Some ☐ None
Current gender of sex partner(s) (check all that apply): ☐ Male ☐ Transgender (male to female) ☐ Female ☐ Transgender (female to male)
Please list the number of sexual partners you have had within the last 60 days: _____
Please list the number of lifetime sexual partners you have had: _____
What type of sex are you having (check all that apply)? ☐ Oral ☐ Vaginal ☐ Anal ☐ Not currently sexually active

Have you ever had an HIV test? ☐ Yes, result and date: _____ ☐ No
Have you been vaccinated for Hepatitis B? ☐ Yes, when?: _____ ☐ No
Have you been vaccinated for Hepatitis A? ☐ Yes, when? _____ ☐ No
Have you been vaccinated for HPV? ☐ Yes, when? _____ ☐ No

Do you know if you have recently been exposed to any STDs, HIV or Viral Hepatitis?
☐ Yes, specify disease and date: _____ ☐ No
Have you had a positive STD, HIV, or Viral Hepatitis test in the past 12 months?
☐ Yes, specify disease and date: _____ ☐ No

Females:
Are you pregnant? ☐ Yes, due date: _____ ☐ Possibly ☐ No ☐ Unknown
Date of last pelvic exam/pap test: _____ ☐ Unknown

Acknowledgement of Receipt of Notice of Privacy Practices

The Notice of Privacy Practices describes how the Wyoming Department of Health (WDH) may use or disclose your medical information and your ability to access this information. Not all situations will be described within the document. The WDH is required to give you a notice of our privacy practices for the information we collect and keep about you.

I have received and read the WDH Notice of Privacy Practices and have had a chance to ask questions about how my information will be used.

Client's Signature: _____ Date: _____

Provider Initials: _____ Date: _____

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Please select boxes pertaining to you (check all that apply)

- ☐ You are currently pregnant
- ☐ Injection drug use, even one time
- ☐ Infected with HIV
- ☐ Born in Asia, Africa or South America
- ☐ Parents born in Asia, Africa or South America
- ☐ Have a household contact positive for Hepatitis B
- ☐ Current or history of hemodialysis
- ☐ Receiving chemotherapy or other immunosuppressive therapy
- ☐ Current or history of incarceration
- ☐ Have had more than one sexual partner in past 60 days
- ☐ New sexual partner in past 60 days
- ☐ Exposure to a STD in past 60 days
- ☐ Current or history of homelessness
- ☐ 13-26 years old and had unprotected sex
- ☐ Have a history of prior STD's or Hepatitis
- ☐ Unprotected anal, oral or vaginal sex
- ☐ History of working in a health care setting
- ☐ Have a current or prior sexual partner positive for Hepatitis B or C
- ☐ Consistently abnormal liver tests
- ☐ Mother positive for HIV, Hepatitis B or C
- ☐ Sexual intercourse with a current or former injection drug user
- ☐ History of blood exposure (under skin or mucous membranes)
- ☐ Born between 1945-1965 (Baby Boomer)
- ☐ Recipient of clotting factor or blood concentrates prior to 1987
  Date:_____
- ☐ Recipient of blood transfusions, blood components or organ transplants prior to 1992
  Date: _____
- ☐ Tattoos, Date(s): _____
  Type:
  - ☐ Professional setting
  - ☐ Unprofessional setting
  - ☐ Other:_____

Symptoms (check all that apply):

- ☐ Yellowing of the skin or clay colored stools
- ☐ Having abnormal penile or vaginal discharge
- ☐ Have penile, vaginal, anal or oral warts, sores or lesions
- ☐ Pain or burning with urination
- ☐ Increase frequency of urination
- ☐ Pain or bleeding with sexual intercourse
- ☐ Abdominal or pelvic pain
- ☐ Penile or vaginal itching
- ☐ Abnormal bleeding
- ☐ Night Sweats
- ☐ Fever
- ☐ Rash, generalized or Palmar/Plantar
- ☐ Dysuria
- ☐ Other
  List: _____

If you have selected any of these boxes, you are strongly encouraged by the Wyoming Department of Health to be tested for such infections as: HIV, Hepatitis B, Hepatitis C, Chlamydia, Gonorrhea and Syphilis.

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For Staff Use Only

WDH Voucher collected: ☐ No ☐ Yes→ Knowyo.org voucher #_____

Visit Notes:

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Areas to address with Client	Check or comments
Confidentiality of records discussed (HIPAA)	
Informed Consent (as needed)	
HIV/Hepatitis/STD disease transmission and education	
Identify personal risk behaviors and circumstances	
Offer condoms/dental dams/lube	
Expedited Partner Therapy (if applicable in clinic)	
Allergies	
Vaccinations	

Action Required	Comments
Develop Risk Reduction Plan if needed (specify plan)	
Referrals made (if applicable): If more than one referral has been made please provide that information on a separate page	Clinic Name:_____ Provider Name: _____ Phone Number:_____ Reason:_____

Counseling and Testing

Testing and Results		
Date	**Test**	**Result (Circle One)**
	HIV rapid	Reactive / Non-reactive
	HIV confirmatory (if applicable)	Positive/Negative
	Chlamydia	Positive / Negative
	Gonorrhea	Positive/ Negative
	Syphilis (RPR)	Reactive (titer:_____) / Non-reactive
	Syphilis Confirmatory (FTA, TPPA, etc.)	Positive/Negative
	Hepatitis B Surface Antigen (HBsAg)	Positive / Negative
	Hepatitis B Core Antibody – Total (HBcAb-Tot)	Reactive / Non-reactive
	Hepatitis C	Reactive / Non-reactive

Staff Signature: _____ Date:_____

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Positive Test Results

Post-Test Education and Counseling

Action	Comments
Risk reduction plan reviewed	
Need for follow up testing	
Follow up appointment if needed	
Updates on referrals	
Immunizations, Dates initiated:	Hep A:_____ Hep B:_____ Twinrix:_____ HPV:_____
HIV Services Program if positive	
Partner services	

All positive/reactive tests must be reported to the Wyoming Department of Health Communicable Disease Unit. Please report online through the Electronic Confidential Disease Report (ECDR) at **https://prismdata.health.wyo.gov/** or through the Patient Reporting Investigation Surveillance Manager (PRISM). **Date Reported: _____**

Client received results: Date _____ ☐ In person ☐ By Phone ☐ Certified Letter
☐ Unable to locate patient, provide justification: _____

Treatment

Client treated for: ☐ Chlamydia ☐ Gonorrhea ☐ Syphilis ☐ Not treated, provide justification: _____
Medication provided: Date: _____ Time:_____ (am / pm)

Chlamydia		
☐ Azithromycin 1gm	☐ Doxycycline 100mg bid x 7d	☐ Other: _____

Gonorrhea		
☐ Ceftriaxone 250mg IM	**PLUS**	☐ Azithromycin 1gm PO
		OR
		☐ Doxycycline 100mg qd x 7d

Syphilis		
☐ Primary and Secondary: Benzathine penicillin G 2.4mu IM		
☐ Latent: Benzathine penicillin G 2.4mu IM x 3 doses at weekly intervals		
Dose 1 date:	Dose 2 date:	Dose 3 date:

Notes: _____
_____

Provider prescribing treatment: _____ _____
(Print name and credentials) (Signature)

☐ Medication instructions provided ☐ Disease information sheet provided

Partner Services

The Wyoming Department of Health Communicable Disease Unit Clinic Interview may be used as a reference for Partner Services

Name: _____ DOB: _____
Address: _____
Email: _____ Phone number: _____
Partner Treated: ☐ Yes, date and treatment provided: _____
☐ No, provide justification: _____
EPT Provided: ☐ Yes, date and treatment provided: _____
☐ No, provide justification: _____

Staff Signature: _____ Date: _____